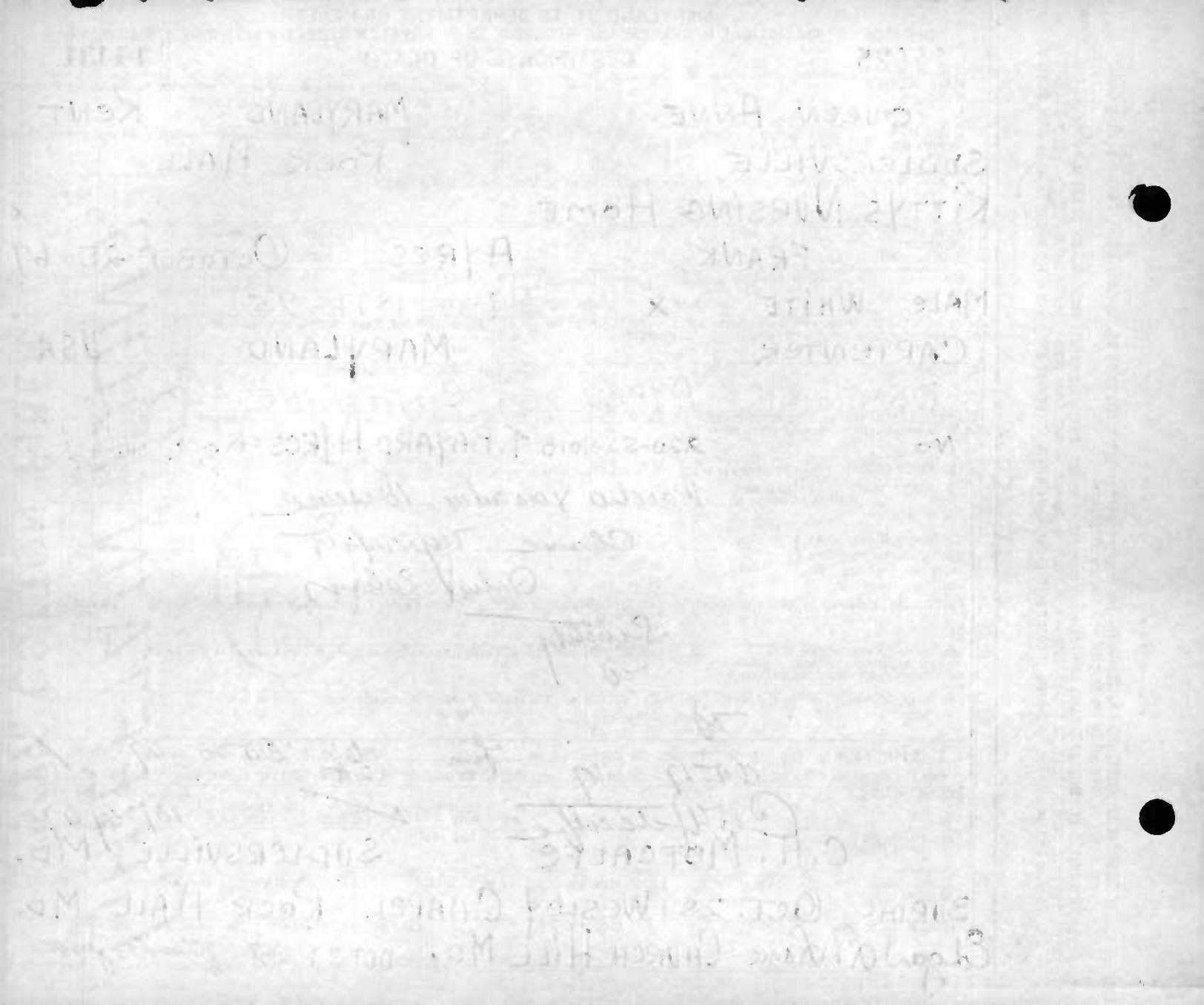


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

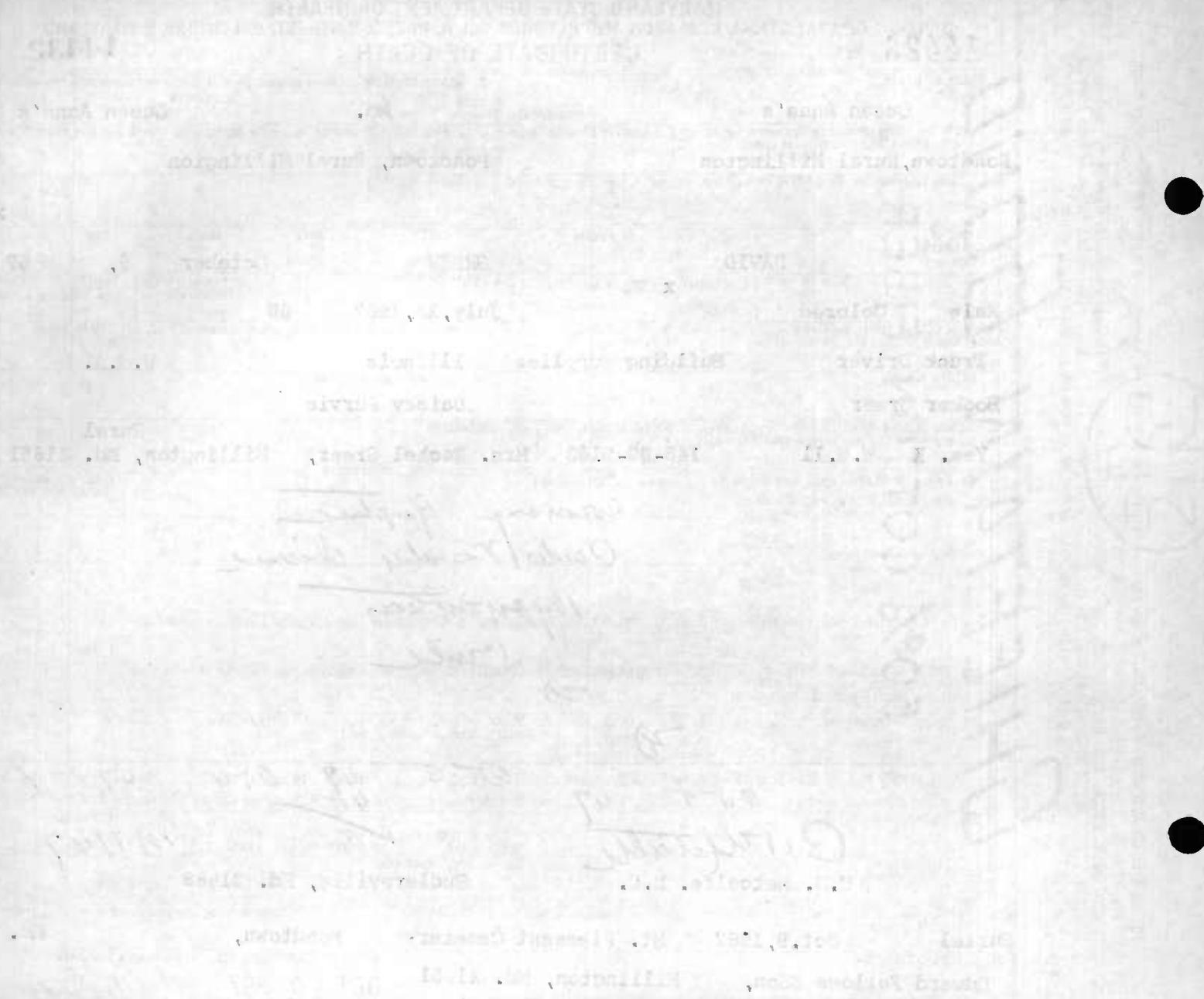
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												14431			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE												
Queen Anne Maryland			MARYLAND												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb												
SUDLERSVILLE															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town)												
KITTY'S NURSING HOME			Rock Hall												
f. STREET ADDRESS			g. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year						
FRANK					AYRES	OCTOBER	25	19	67						
5. SEX			6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?						
MALE			WHITE		9-14-1812	95 yrs.	CARPENTER	MARYLAND	USA						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
CARPENTER						MARYLAND			USA						
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT	Address			
Dominick			AYRES			No			220-52-9013		T. BAYARD AYRES	Rock Hall Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Pneumonia, vascular disease			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.												DUE TO (b) Chronic myocardial (c) Pulmonary			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												Scirrhous			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)
White 19			20												
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19</u> to <u>Oct 25</u> , 1967, that (I) (we) last saw the deceased alive on <u>Oct 19</u> 1967, and that death occurred at <u>2 AM</u> M, from the causes and on the date stated above.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
22a. SIGNATURE												22b. DATE SIGNED			
C. H. METCALFE			M.D.			ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	10/26/67						
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			SUDLERSVILLE MD.									
BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City, town or county) (State)						
BURIAL OCT. 28			Wesley Chapel			Rock Hall MD.									
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Edgar D. Lane - CHURCH HILL MD.						DATE OCT 31 1967			Charles George						
VR A15 (4) 20M 1/65															



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												14432
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne's								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pondtown, Rural Millington				c. LENGTH OF STAY IN 1b								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)												
3. NAME OF DECEASED (Type or print)				First DAVID	Middle	Last GREER	4. DATE OF DEATH October 6, 1967	Month	Day	Year		
5. SEX Male		6. COLOR DR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1907	9. AGE (in years last birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Building Supplies				11. BIRTHPLACE (County & State, or foreign country) Illinois				12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Booker Greer				14. MOTHER'S MAIDEN NAME Daisey Purvis								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) Yes. X W.W.II				16. SOCIAL SECURITY ND. 148-09-9183				17. INFORMANT Mrs. Rachel Greer,				Address Rural Millington, Md. 21651
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN DNSE AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201												
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Rupture												
DUE TO (c) Cardiovascular disease												
DUE TO Hypertension												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Car accident								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sudlersville				20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 5, 1967 , to Oct 4, 1967 that (I) (we) last saw the deceased alive on Oct 5, 1967 , and that death occurred at 6 PM , from the causes and on the date stated above.												22b. DATE SIGNED 10/7/67
22a. SIGNATURE C. H. Metcalfe												M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) C.H. Metcalfe, M.D.												22d. ADDRESS Sudlersville, Md. 21668
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 9, 1967				23c. NAME OF CEMETERY OR CREMATORIUM Mt. Pleasant Cemetery				23d. LOCATION (City, town or county) Pondtown, Md.
24. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md. 21651												ADDRESS ADDRESS Millington, Md. 21651
25a. REC'D BY REGISTRAR DATE OCT 10 1967												25b. REGISTRAR'S SIGNATURE Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14428

CERTIFICATE OF DEATH

14434

1. PLACE OF DEATH a. COUNTY		QUEEN ANNE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GRASONVILLE		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GRASONVILLE 17-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		xx		d. STREET ADDRESS xx	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First MARGURITE	Middle MAE	Last HORNEY	4. DATE OF DEATH Month OCTOBER Day 18 Year 1967
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH W100WE0 <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY xx		11. BIRTHPLACE (County & State, or foreign country) Q.A. Co. MARYLAND USA	
13. FATHER'S NAME GEORGE MILLER		14. MOTHER'S MAIDEN NAME MARY Rose EVANS		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. xx		17. INFORMANT RAYMOND HORNEY - GRASONVILLE Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 30 hr.	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		OUE TO (b)	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Rheumatoid Arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) GRASONVILLE	(County) MARYLAND (State)
21. I certify that (I) (this hospital) attended the deceased from 4-1, 1967 to 10-18, 1967, that (I) (we) last saw the deceased alive on 10-18, 1967, and that death occurred at 12:20 M, from the causes and on the date stated above.		22b. DATE SIGNED 10-20-67			
22a. SIGNATURE Ralph E. Libby		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS GRASONVILLE MARYLAND		
22c. PHYSICIAN'S NAME (Type) RALPH E. LIBBY		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL OCT. 21			
		23b. DATE THEREOF OCT. 21			
		23c. NAME OF CEMETERY OR CREMATORIAL CHESTERFIELD			
		23d. LOCATION (City, town or county) CENTREVILLE MD (State)			
24. FUNERAL DIRECTOR Edgar L. Lane		25a. REC'D BY REGISTRAR CHURCH HILL MD OCT 24 1967			
		25b. REGISTRAR'S SIGNATURE Charles Judge			

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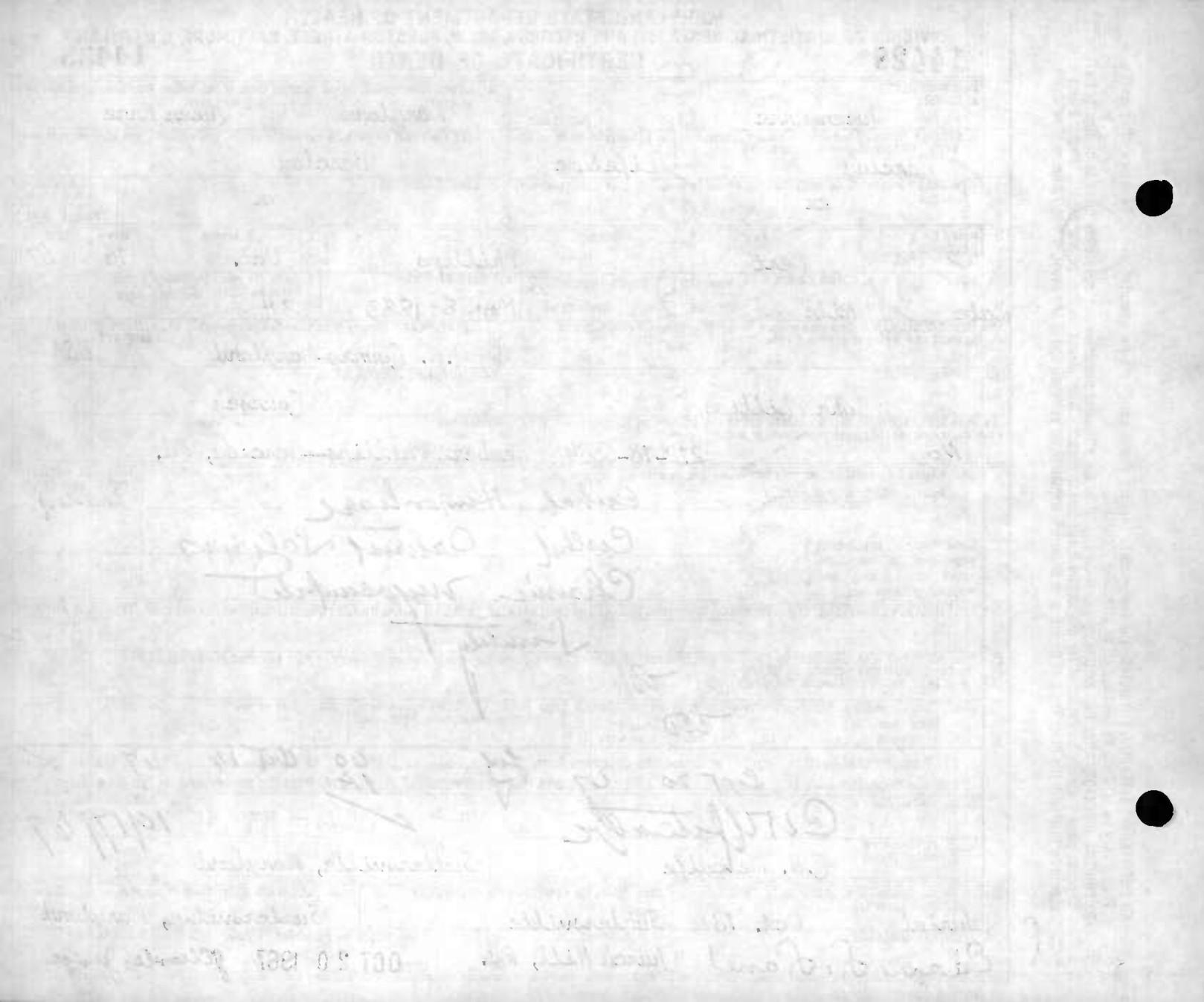
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14429 CERTIFICATE OF DEATH 14435

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barclay</i>	c. LENGTH OF STAY IN 1b <i>Lifetime</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>xx</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barclay</i>						
3. NAME OF DECEASED (Type or print) <i>Bert</i>	First <i>Bert</i>	Middle <i></i>	Last <i>Phillips</i>	4. DATE OF DEATH <i>Oct.</i>	Month <i>Oct.</i>	Day <i>16</i>	Year <i>19 67</i>
5. SEX <i>Male</i>	6. COLDLR DR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDWED <input type="checkbox"/> DIVDRCD <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR. 8 - 1883</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Q.A. County-Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Phillips</i>				14. MOTHER'S MAIDEN NAME <i>Coursey</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>212-18-6884</i>	17. INFORMANT <i>Rembert Phillips-Barclay, Md.</i>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterial Hypertension</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i>Chronic Myocarditis</i> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Smoking</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>Fullday</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>By</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED <i>Not White</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>at work</i>	20f. (City or town) <i>Sudlersville</i>	(County) <i></i>	(State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 19 <i>60</i> , to <i>Oct 16</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Sept 20</i> 19 <i>67</i> , and that death occurred at <i>1 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>C. H. Metcalfe</i>				22b. DATE SIGNED <i>10/17/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>C. H. Metcalfe</i>		22d. ADDRESS <i>Sudlersville, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 18</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Sudlersville Church Hill, Md.</i>	23d. LOCATION (City, town or county) <i>Sudlersville, Maryland</i>			
24. FUNERAL DIRECTOR <i>Edgar S. Lane</i>		25a. REC'D BY REGISTRAR <i>OCT 20 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
DATE							



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

If any delay is
necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form
PM3. Page 5 may be retained for your files.

14430

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14436

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill		c. LENGTH OF STAY IN lb Most of Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Clara	Middle Elizabeth	Last Wells	4. DATE OF DEATH Oct 11 1967	Month Oct	Day 11	Year 1967
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1899	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) Queen Anne County, Md.	12. CITIZEN OF WHAT COUNTRY? USA
---	---	--	--

13. FATHER'S NAME Andrew Parker	14. MOTHER'S MAIDEN NAME Mary Jane Martin
---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. ----- None -----	17. INFORMANT Edith Riley, Church Hill, Md.
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) 723.0		30 mins
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) if any, which gave rise to the underlying cause (a). Degenerative Arteriosclerosis		5 year
DUE TO Arteriosclerosis Heart Disease		8 year
(c) Degenerative Arteriosclerosis		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
--	--	---

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED
--	--	-----------------

ACTUAL SIGNATURE <i>John R. Smith Jr. M.D.</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) John R. Smith, Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county)		

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/14/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Salem Cemetery Cambridge, Md.	23d. LOCATION (City or Town) (County) (State) Browns Corner, QA Co. Md.
24. FUNERAL DIRECTOR <i>Katherine K. Clark</i>	ADDRESS <i>Cambridge, Md.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>OCT 19 1967</i>

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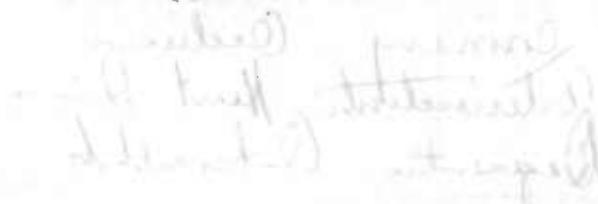
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